Illinois Department of Public Aid

201 South Grand Avenue East
Springfield, Illinois 62763-0001

Rod R. Blagojevich, Governor
Barry S. Maram, Director

Telephone: (217) 785-0710
TTY: (800) 526-5812

March 5, 2004

To: Chief Executive Officers, Chief Financial Officers, and Patient Account Managers

Attached you will find an Action Notice from the Department reminding hospitals of the information used to calculate Disproportionate Share Hospital Adjustment Payments, Medicaid Percentage Adjustment Payments, Critical Hospital Adjustment Payments, and County Trauma Center Adjustment Payments.

The purpose of the attached notice is to remind hospitals that the Department will make determinations based on data on hand and allow you to update information you feel is incomplete. As described in the attachments, claims must be adjudicated no later than June 30, 2004, and other data must be received or postmarked no later than July 1, 2004. Data used to determine eligibility and calculate rates are not from the current period, but from either your hospital's 2002 cost reporting period or the State's 2003 (July 1, 2002 to June 30, 2003) fiscal year. If you have any questions regarding this notice, please contact the Disproportionate Share Unit at (217) 785-0710.

Sincerely,

Andrew Kane, Administrator
Division of Finance

Attachments

Illinois Department of Public Aid

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ACTION NOTICE

PLEASE NOTE THE REQUIRED DEADLINES DESCRIBED BELOW

To: Cost Reporting Hospitals: CEO, CFO, and Patient Account Manager

RE: Rate Year 2005 Determination for Disproportionate Share, Medicaid Percentage Adjustment, Critical Hospital Adjustment, and County Trauma Center Adjustment Payments

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This notice describes the information required by the Department to determine which hospitals will qualify for Disproportionate Share Hospital Adjustment Payments, Medicaid Percentage Adjustment Payments, Critical Hospital Adjustment Payments, and County Trauma Center Adjustment Payments in accordance with the 89 Illinois Administrative Code Sections, 148.120, 148.122, 148.290(c), and 148.295 in rate year 2005. **Claims Data must be received and adjudicated by the Department by June 30, 2004. The Illinois Administrative Code provides for no exceptions to that deadline.**

CRITICAL HOSPITAL ADJUSTMENT PAYMENTS (CHAP) and COUNTY TRAUMA CENTER ADJUSTMENT PAYMENTS (TCA)

In order to determine eligibility and payment rates for both Critical Hospital Adjustment Payments and County Trauma Center Adjustments, all data defined in Sections 148.290(c), and 148.295 of the Illinois Administrative Code must be adjudicated by June 30, 2004. This includes trauma admissions, obstetrical days, general care admissions, and certain rehabilitation admissions as defined in the sections cited above. Services provided in state fiscal year 2003 (July 1, 2002 - June 30, 2003) for which claims have been received and adjudicated by June 30, 2004, will be used to determine eligibility for these payments. **Data which have not been adjudicated by June 30, 2004, cannot be considered by the Department.**

DISPROPORTIONATE SHARE (DSH) and MEDICAID PERCENTAGE ADJUSTMENT (MPA) DETERMINATION

The information required by the Department for the Disproportionate Share and Medicaid Percentage Adjustment determination is outlined below. Items 1 through 4 apply to all Illinois hospitals. Out-of-state cost reporting hospitals need only to submit the information required under items 1 and 4. The information needed to calculate Medicaid utilization levels for out-of-state hospitals will be obtained from the Medicaid agency in that state. **Please note that all required information submitted must be based on your hospital's 2002 cost reporting period statistics.**

1) Hospitals providing non-emergency obstetrical care to the general public must provide, in writing, the names of at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetrical services to individuals entitled to Illinois Medicaid. Hospitals not offering non-emergency obstetrical care to the general public must provide a statement to that effect. **Please complete Part I <u>OR</u> Part II of the Disproportionate Share Obstetrical Statement and return it to the Department by July 1, 2004.**

2) In making the determination, the Department will utilize final audited cost reports for each hospital's 2002 cost reporting period. In the absence of a final audited cost report, the Department will utilize the hospital's unaudited cost report. Data derived from audited cost reports will be considered final. **If your hospital's cost report is unaudited and you feel relevant data therein are incorrect, a corrected cost report must be received or postmarked by July 1, 2004 (metered dates are not acceptable). In accordance with section 148.120(c)(1), cost report corrections received or postmarked beyond July 1, 2004, cannot be considered.**

3) Certain types of inpatient days of care provided to Title XIX recipients are not available from the cost report. They are: (1) Medicare/Medicaid crossover days, (2) hospital residing long term care days, (3) Illinois Department of Alcohol and Substance Abuse (DASA) days, (4) Medicaid HMO days, and (5) Out-of-state Title XIX Medicaid utilization levels.

    a) The Department will utilize the Department's paid claims data for each hospital's 2002 cost reporting period to determine the number of Medicare/Medicaid crossover days, hospital residing long term care days, and DASA days. All claims must be adjudicated by June 30, 2004 to be included in the determination and rate setting process.

    b) The Department will request a special report from each HMO to determine the number of HMO days for each hospital’s 2002 cost reporting period.

    c) Hospital statements and verification reports from other States will be required to verify out-of-state Medicaid recipient utilization levels. The information submitted must include only days of care provided to out-of-state Medicaid recipients during the hospital's 2002 cost reporting period.

4) Hospitals may also qualify for Disproportionate Share status if their low income utilization rate exceeds 25%. To calculate a hospital's low income utilization rate, the hospital must fill out the attached Low Income Utilization Collection Form, and submit an audited certified financial statement for their 2002 cost reporting period.

All information described in Sections 1 through 4 above is necessary to conduct the rate year 2005 Disproportionate Share and Medicaid Percentage Adjustment determination <u>and</u> must be received by, or postmarked to the Department no later than July 1, 2004, at the appropriate address listed below. Information for Sections 1 through 4 above that is postmarked after July 1, 2004, will not be considered for the Disproportionate Share or Medicaid Percentage Adjustment determination.

OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA'93)

In order to determine if the Department meets federal guidelines set forth in the Omnibus Budget Reconciliation Act of 1993 (OBRA'93), all cost reporting hospitals must complete and send the OBRA'93 Data Collection Form to the Department BY AUGUST 15, 2004 (mail postmarked on or before that date is acceptable: metered dates are not acceptable), with the following information for the hospital's 2002 cost reporting period.

1. The dollar amount of Illinois inpatient and outpatient Medicaid charges.

2. The dollar amount of total inpatient and outpatient hospital charity care charges incurred for services provided to individuals without health insurance or other source of third party coverage

3. The dollar amount of total inpatient and outpatient bad debt incurred by the hospital, less any recoveries for services provided to individuals without health insurance or other source of third party coverage (not including charges reported under charity care, above)

4. The dollar amount of total inpatient and outpatient charges incurred by the hospital (includes all financial classes).

NOTES: Outpatient includes hospital outpatient services and hospital based clinic services only.

For items 2 and 3, do not include unpaid co-pays or third party obligations of **insured patients**, contractual allowances, or the hospital's charges or reduced charges attributable to services provided under its obligation pursuant to the federal Hill-Burton Act).

For items 2 and 3, state or unit of local government payments made to a hospital on behalf of indigent parties (ie. Transitional Assistance and Family and Children Assistance), shall not be considered to be a form of insurance or a source of third party coverage. Therefore, unreimbursed charges for persons covered under these programs may be included.

In the case of a new hospital, please submit the above-required information from the time your hospital began operating through the hospital's cost reporting period. Please indicate the date your hospital began operating.

FAILURE TO PROVIDE THE REQUIRED OBRA'93 INFORMATION, SEPARATED BY INPATIENT AND OUTPATIENT CHARGES, BY AUGUST 15, 2004, MAY RESULT IN THE HOSPITAL RECEIVING A LOWER DISPROPORTIONATE SHARE RATE OR BEING INELIGIBLE FOR DISPROPORTIONATE SHARE PAYMENTS IN RATE YEAR 2005.

APPEALS

The Department will mail rate year 2005 CHAP, TCA, DSH and MPA rate notices to all cost reporting hospitals. In accordance with section 148.310 of the Illinois Administrative Code, hospitals will have thirty days from the date of the rate notice to make appeals. **All appeals must include detailed challenges to the rate. The Department cannot accept appeals submitted beyond the thirty day limit nor can it accept, as a substantive appeal, letters that only request an extension of the thirty day limit.**

SUBMITTAL OF INFORMATION

Corrected cost report information, audited certified financial statements, and the OBRA'93 data collection form must be submitted to the following address:

Illinois Department of Public Aid
Office of Health Finance
Hospital Audit Section
201 South Grand Avenue East – Lower Level
Springfield, Illinois 62763-0001
FAX (217) 782-2812

Note: Audited certified financial statements must only be submitted if the hospital's low income utilization rate exceeds 25% for the Disproportionate Share and Medicaid Percentage Adjustment determination. Corrected cost reports must only be submitted if your hospital's 2002 cost report is unaudited and you feel it is incorrect.

All other information required for the Disproportionate Share and Medicaid Percentage Adjustment determination (obstetrical statement, and out-of-state Medicaid utilization levels) must be submitted to:

Illinois Department of Public Aid
Bureau of Rate Development and Analysis
Disproportionate Share Unit
201 South Grand Avenue East, 2nd Floor
Springfield, Illinois 62763-0001
FAX (217) 524-9403

Questions regarding cost report information, certified financial statements and the OBRA'93 form should be directed to the Office of Health Finance at (217) 782-1630. All other questions should be directed to the Bureau of Rate Development and Analysis at (217) 785-0710.

Andrew Kane, Administrator
Division of Finance

ATTACHMENTS

DISPROPORTIONATE SHARE OBSTETRICAL STATEMENT
RATE YEAR 2005

COMPLETE EITHER PART I OR PART II

PART I: To be completed only by those hospitals providing non-emergency obstetrical services to the general public.

The following obstetricians have staff privileges at the hospital named below and have agreed to provide non-emergency obstetrical services for Illinois Medicaid beneficiaries:

Physician's Name: _____
(Typed)

Physician's Name: _____
(Typed)

Additional names may be submitted as an attachment to this form.

PART II: To be completed only by those hospitals that do not provide non-emergency obstetrical services to the general public.

Federal law prohibits States from making disproportionate share payment adjustments to hospitals that discontinue providing non-emergency obstetrical services to the general public after December 22, 1987. Hospitals that do not offer non-emergency obstetrical services to the general public must state so below:

_____ has not offered
(Name of Hospital)
non-emergency obstetrical services to the general public since _____.
(Date)

_____
(Signature)

Return the form by July 1, 2004, to:

_____
(Typed Signature)

Illinois Department of Public Aid
Bureau of Rate Development and Analysis
Disproportionate Share Unit
201 South Grand Avenue East, 2nd Floor
Springfield, IL 62763-0001

_____
(Title)

_____
(Typed Hospital Name)

_____
(Typed Address)

_____
(Typed Address)

_____
(Phone Number/FAX Number)

RATE YEAR 2005 OBRA'93 DATA COLLECTION FORM

(Information based upon hospital's fiscal year 2002 cost reporting period)
(Response required by August 15, 2004)

This form will be REJECTED if inpatient and outpatient charges are not separated.

HOSPITAL: _____

CITY / STATE: _____

ALL COST REPORTING HOSPITALS MUST SUBMIT THE FOLLOWING INFORMATION FOR THE HOSPITAL'S
2002 COST REPORTING PERIOD: BEGIN DATE: _____ END DATE: _____

	INPATIENT	OUTPATIENT *	TOTAL
1. **Illinois Medicaid Charges:** (excluding charges for Medicaid MCO clients)			
2. a. **Hospital charity care charges for services provided to individuals without health insurance or other source of third party coverage: **** All uninsured patients*** (out of state hospitals provide Illinois only)			
b. **Hospital bad debt less any recoveries for services provided (do not include charges reported under charity care above): **** All Patients (out of state hospitals provide Illinois only)			
Insured patients only			
Net bad debt for uninsured patients*** (all patients minus insured patients)			
3. **Illinois Total Hospital Charges: ******			

* Includes hospital outpatient services and hospital based clinic services only.

** Do not include contractual allowances, or the hospital's charges or reduced charges attributable to services provided under its obligation pursuant to the federal Hill-Burton Act.

State or unit of local government payments made to a hospital on behalf of indigent patients (i.e. Transitional Assistance and State Family and Children Assistance) shall not be considered to be a form of insurance or a source of third party coverage. Therefore, unreimbursed charges for persons covered under these programs may be included.

*** Federal law requires the collection of charity care and bad debt for uninsured patients only.

**** Hospital charges includes all financial classes.

I CERTIFY that to the best of my knowledge the above information is true and correct.

The above information is based upon: ☐ audited financial statements and supporting schedules.
(please check the box that applies) ☐ unaudited financial statements and supporting schedules.

This form must be submitted to:
Illinois Department of Public Aid
Office of Health Finance
201 South Grand Avenue East - Lower Level
Springfield, Illinois 62763-0001

Phone (217)782-1630 Fax (217)782-2812

_____
Authorized Signature

_____
Name (Typewritten)

_____
Title (Typewritten)

_____ ( )
Date Phone

LOW INCOME UTILIZATION COLLECTION FORM

(Response required by July 1, 2004)

INCOMPLETE forms will be REJECTED

HOSPITAL:

CITY / STATE:

FISCAL YEAR END: , 2002

This form, in addition to audited financial statements and any other supporting documentation, must only be submitted if the hospital's low income utilization rate exceeds 25% for disproportionate share determination.

	Amount	List Attached Financial Statement or Supporting Documentation	List Workpaper Reference (i.e., pg. 1, item 1)
1. TOTAL PAYMENTS RECEIVED DIRECTLY FROM STATE AND LOCAL GOVERNMENTS for all patient services, both inpatient and outpatient	$		
2. TOTAL HOSPITAL NET REVENUE for all patient services, both inpatient and outpatient	$		
3. TOTAL GROSS INPATIENT HOSPITAL CHARGES FOR CHARITY CARE (This must not include unreimbursed cost, contractual allowances, bad debts or discounts, except contractual allowances and discounts for Family and Children Assistance (formerly known as General Assistance) and Aid to the Medically Indigent patients. Inpatient charity care charges may be calculated based on the ratio of inpatient to total gross hospital charges if the provider's records do not distinguish inpatient from total charity care).	$		
4. TOTAL HOSPITAL GROSS CHARGES FOR INPATIENT HOSPITAL SERVICES	$		

I CERTIFY that to the best of my knowledge, the above information is true and correct.

This form must be submitted to:

Illinois Department of Public Aid
Office of Health Finance
201 South Grand Avenue East - Lower Level
Springfield, Illinois 62763-0001

Phone (217)782-1630 Fax (217)782-2812

Authorized Signature

Name (Typewritten)

Title (Typewritten)

Date

( ) Phone